Charles County Government Qualifying Event Form FY15

The Human Resources Department must receive this form, your enrollment form, and documentation within 31 calendar days of the event.
Benefit changes must be on account of and consistent with the event.

Employee Name (please print):_____

SSN: XXX-XX-_____ Day Phone #: _____ Date of Event: _____

Please indicate your qualifying event:

[ ] Marriage – *Copy of marriage certificate must be attached*
_____ Opposite Sex Marriage
_____ Same Sex Marriage *(Affidavit for Spousal Eligibility and Tax Status must also be attached)*

[ ] Divorce – *Copy of final divorce decree must be attached*
Provide address of former spouse: _____
_____
_____

[ ] Birth of child – *provide documentation of birth and SSN upon receipt (no later than 60 days)*

[ ] Adoption, custody or guardianship – *Copy of custody paper must be attached*

[ ] Death – *Copy of death certificate must be attached*

[ ] Change in your employment status *(part-time to full-time, full-time to part-time, unpaid leave)*

[ ] Change of Spouse's employment status – S*ee attached page for documentation needed*
Date eligible for CCG plan: _____
Date lost eligibility for CCG plan: _____

[ ] Significant change in spouse's employer coverage –
See attached page for documentation needed
(Note: This event is not a qualifying event for Health Care FSAs)

[ ] Spouse's Open Enrollment - S*ee attached page for documentation needed*
Effective date of change: _____
(Note: This event is not a qualifying event for Health Care FSAs)

[ ] Loss of coverage due to: _____
See attached page for documentation needed

[ ] Child no longer eligible (reached age 26 or is eligible for health/dental insurance through their own employer)

[ ] Election of Supplemental Life Insurance

[ ] Other _____

Employee Signature: _____ Date: _____

Changes for birth, adoption, death and marriage are effective the date of the event. Other mid-year changes will be effective the first of the month following date of the event.

Enrollment Form

Note: All costs shown are per pay period costs

Medical/Vision or Dental: (Circle Election)	PPO/CF Vision	HMO/CF Vision	CF Dental	Delta Dental
Employee	$ 98.62	$ 61.65	$ 5.57	$ 4.91
Employee + Child	$171.35	$117.15	$ 8.50	$ 7.80
Employee + Spouse	$205.24	$141.79	$12.77	$11.58
Family	$241.28	$184.95	$16.71	$15.04
	Waive Coverage	Waive Coverage	Waive Coverage	Waive Coverage

AFLAC

_____ Critical Illness Complete Change/Application Form
_____ Accident Policy Complete Change/Application Form

Legal Resources: _____ Add Dependent(s) _____ Remove Dependent(s)

Flexible Spending Account: _____Medical Amount: $_____
_____Dependent Amount: $_____

Enroll/Waive in Dependent Life Insurance: ($5,000 policy on dependent child (ren) and $10,000 policy on spouse)
_____ Add _____ Waive

Apply for Supplemental Life Insurance ____ 1X ____2X ____3X salary

Please list all who will be affected by change, including self

Self

Name SS# Gender DOB

Home Address City State Zip

Please check box of the benefit(s) you would like to: Medical and Vision □Enroll □ Waive
Dental □Enroll □ Waive

For HMO coverage, please indicate the provider's name: _____

Dependent #1

Name SS# Relationship (spouse/child) Gender DOB

Home Address City State Zip

Please check box (if applicable): □ Eligible child □ Over-age Handicapped Child
Please check box of the benefit(s) you would like to: Medical and Vision □ Enroll □ Waive
Dental □ Enroll □ Waive

For HMO coverage, please indicate the provider's name: _____

Dependent #2

Name SS# Relationship (spouse/child) Gender DOB

Home Address City State Zip

Please check box (if applicable): □ Eligible child □ Over-age Handicapped Child
Please check box of the benefit(s) you would like to: Medical and Vision □ Enroll □ Waive
Dental □ Enroll □ Waive

For HMO coverage, please indicate the provider's name: _____

Primary/Contingent Beneficiary Information

Name: _____ **Date:** _____

(Please Print)

Basic Life (1.5 times your salary), Accidental Death & Dismemberment Insurance and Supplemental Life Insurance (if applicable) Beneficiary

Beneficiary Name	Beneficiary SSN	Beneficiary Address	Beneficiary Date of Birth	Relationship	Primary? Y/N	Contingent? Y/N	Percentage Allocation

Pension Beneficiary

Beneficiary Name	Beneficiary SSN	Beneficiary Address	Beneficiary Date of Birth	Relationship	Primary? Y/N	Contingent? Y/N	Percentage Allocation

Payroll Beneficiary

Beneficiary Name	Beneficiary SSN	Beneficiary Address	Beneficiary Date of Birth	Relationship	Primary? Y/N	Contingent? Y/N	Percentage Allocation

Percentage Allocations of all beneficiaries (Primary and Contingent) must equal 100%. This means that your Primary beneficiaries must equal 100% and your Contingent beneficiaries must equal 100%.

Employee Signature: _____ **Date:** _____

Qualifying Events
Documentation

Qualifying Event	Documentation Needed
Change of spouse's employment status	HIPAA Certificate from former plan **OR** Letter on employer's letterhead stating: • Date prepared • Name of employee and covered dependents • Name of employer providing coverage • Date coverage ended (if adding spouse/dependents to county coverage) OR Date coverage will begin (if dropping spouse/dependents from county coverage) • Name of carrier • Employer contact name, phone number, address
Significant change in spouse's employer coverage	Letter on spouse's employer's letterhead stating: • Date prepared • Name of employer providing coverage • Name of employee and covered dependents • Name of current carrier • Description of significant change in coverage • Effective date of significant change in coverage • Employer contact name, phone number, address
Spouse's Open Enrollment - Benefits Plan Year is different from the County's	Letter on spouse's employer's letterhead stating: • Date letter is prepared • Name of Spouse's employer • Name of Spouse/dependents changing coverage • Date coverage change is effective • Employer contact name, phone number, address
Loss of Coverage	HIPAA Certificate from former plan **OR** Letter on prior employer's letterhead stating: • Date letter is prepared • Name of employer that provided coverage • Name of employee/dependents losing coverage • Date coverage ends • Name of prior carrier • Employer contact name, phone number, address

Letters may be addressed and sent to the employee, OR FAX to:
Charles County Human Resources Department Benefits Division,
Phone 301-645-0585 **FAX: 301-396-8862**

Qualifying Event Form, Enrollment Form(s), and documentation **MUST** be received in the Human Resources Benefits Division **within 31 days of the qualifying event.**